Respite Subsidy Application
Respite Subsidy Program Across the Lifespan

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE • DEPARTMENT OF FINANCE AND SUPPORT

Section 1 GENERAL INFORMATION

Name of Person with Special Needs			Birthdate
Mailing Address			**Social Security Number**
City	County	Zip Code	Telephone

Caregiver's Name (person residing with above named person as the usual caregiver)	Relationship to Person with Special Needs

Indicate the total number of people who live in the household of the person with special needs.

Name	**Date of Birth**	**Relationship to person with special needs**

Section 2 DISABILITY

1. Please describe the person's special needs. Include the person's medical diagnosis, if known. Attach additional sheet, if necessary.

2. Explain Caregiver's need for respite (relief time away from caregiving responsibilities).

Section 3 SUPPORT SERVICES

1. Are you now receiving any financial assistance for respite? ❑ Yes ❑ No
   If yes: Who pays for the respite? _____
2. Is the person with special needs receiving services from: (check all that apply)
   ❑ Health Insurance ❑ Medicaid ❑ Developmental Disabilities System
   If yes: Name of health insurance company_____

Section 4 RESOURCES/ASSETS

List any cash, checking accounts, stocks, bonds, whole life insurance, certificates of deposit, etc., and any assets that can be converted to cash.
Include assets belonging to person with special needs, their spouse and children under 19. If a person with special needs is under 19, include parents and siblings under 19.

Asset	**Whose is it?**	**Amount**

MILTC-1400 Rev. 9/03 (36005)
(Previous version 7/02 should be used first - version 10/01 should not be used)

Section 5 INCOME

List all gross income (before deductions). Include person with special needs, their spouse and children under 19.
If person with special needs is under 19, include parents and siblings under 19.

Income Type	Kind of Income	Amount	How Often is it Received	Who Receives it
Wages, Self-Employment				
Assistance Programs (Social Security, SSI, ADC, Veterans)				
Interest, Dividends				
Child Support, Alimony				
Other:				

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Section 6 DISABILITY-RELATED EXPENSES

List all disability-related expenses the person with special needs has to pay in a year's time. Do not include amounts covered by insurance or other benefit program(s). Examples of expenses: doctor visits, prescriptions, diapers, medical transportation, wheel chairs, lifts, loans for architectural modification. Do not include expenses of other family members.

What Expense	How Much Cost	How Often	Whose Expense

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Section 7 AGREEMENT AND SIGNATURE

I understand that my statements may be checked, and if I have given false statements or information, I may be found guilty of fraud.

I understand that whenever there are any changes in the information I have given, I must immediately report them to the Nebraska Department of Health & Human Services.

I understand that if I do not think my request is handled correctly, I have the right to file an appeal.

I understand that the Nebraska Department of Health and Human Services may need to contact other agencies and individuals to determine my financial eligibility and to verify my need for the support for which I am applying, or to make referrals to assist me in obtaining services. I authorize the release of this confidential information.

Payments for benefits may be delayed if you did not complete Social Security # for person with special needs.

Signature of Person with Special Needs or Parent or Guardian	Date Signed
Signature of Person who Helped Complete this Application, If Applicable	Date

Send completed application to: Nebraska Department of Health & Human Services
Aging & Disability Services
P.O. Box 95044
Lincoln, NE 68509-5044

Questions? Call toll-free: 1-800-358-8802 or in Lincoln: 471-9310